REQUEST FOR
TEMPORARY DUTY ASSISTANCE

Department Name: _____ **Today's Date:** _____

Contact Person: _____ **Phone Number:** _____

Position To Be Filled:

Duration of Position:
Start Date : _____ **/ End Date:** _____

Location of Position:

Work Days:	**Work Times:**
☐ **8 hours daily/ 5 days per week**	**Start Time** _____**a.m. / p.m.**
☐ **10 hours daily/ 4 days per week**	**End Time:** _____**a.m. / p.m.**
☐ **Other (please specify):** _____	

Brief Description of Duties:

Additional Comments: _____

FOR RISK MANAGEMENT USE ONLY:

Temporary Duty Employee Assigned:

Date Employee Assigned:

Additional Comments: _____

THIS RECEIPT SHALL BE READ AND SIGNED BY THE EMPLOYEE. RISK MANAGEMENT SHALL COUNTERSIGN THE RECEIPT AND PLACE IT IN THE EMPLOYEE'S WORKER'S COMPENSATION FILE.

Employee's Signature: **Date:**

Risk Management: **Date:**

cc: Employee's Home Department